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- (i) The Part D plan sponsor may not require the enrollee to request approval for a refill, or a new prescription to continue using the Part D prescription drug after the refills for the initial prescription are exhausted, as long as—
- (A) The enrollee's prescribing physician or other prescriber continues to prescribe the drug;
- (B) The drug continues to be considered safe for treating the enrollee's disease or medical condition; and
- (C) The enrollment period has not expired. If an enrollee renews his or her membership after the plan year, the plan may choose to continue coverage into the subsequent plan year.
- (ii) The Part D plan sponsor must not establish a special formulary tier or co-payment or other cost-sharing requirement that is applicable only to prescription drugs approved for coverage under this section.
- (iii) An enrollee may not request a tiering exception for a non-formulary prescription drug approved under § 423.578(b).
- (d) Notice regarding formulary changes. Whenever a Part D plan sponsor removes a covered part D drug from its formulary or makes any changes in the preferred or tiered cost-sharing status of such a drug, the Part D plan sponsor must provide notice in accordance with § 423.120(b)(5).
- (e) Limitation of the exceptions procedures to Part D drugs. Nothing in this section may be construed to allow an enrollee to use the exceptions processes set out in this section to request or be granted coverage for a prescription drug that does not meet the definition of a Part D drug.
- (f) Implication of the physician's or other prescriber's supporting statement. Nothing in this section should be construed to mean that the physician's or other prescriber's supporting statement required for an exceptions request will result in an automatic favorable decision.

[70 FR 4525, Jan. 28, 2005, as amended at 74 FR 1546, Jan. 12, 2009]

§ 423.580 Right to a redetermination.

An enrollee who has received a coverage determination (including one that is reopened and revised as described in §423.1978) may request that

it be redetermined under the procedures described in §423.582, which address requests for a standard redetermination. The prescribing physician or other prescriber (acting on behalf of an enrollee), upon providing notice to the enrollee, may request a standard redetermination under the procedures described in §423.582. An enrollee or an enrollee's prescribing physician or other prescriber (acting on behalf of an enrollee) may request an expedited redetermination as specified in §423.584.

[74 FR 1547, Jan. 12, 2009, as amended at 74 FR 65363, Dec. 9, 2009]

§ 423.582 Request for a standard redetermination.

- (a) Method and place for filing a request. An enrollee or an enrollee's prescribing physician or other prescriber (acting on behalf of the enrollee) must ask for a redetermination by making a written request with the Part D plan sponsor that made the coverage determination. The Part D plan sponsor may adopt a policy for accepting oral requests.
- (b) Timeframe for filing a request. Except as provided in paragraph (c) of this section, a request for a redetermination must be filed within 60 calendar days from the date of the notice of the coverage determination.
- (c) Extending the time for filing a request—(1) General rule. If an enrollee or prescribing physician or other prescriber acting on behalf of an enrollee shows good cause, the Part D plan sponsor may extend the timeframe for filing a request for redetermination.
- (2) How to request an extension of time-frame. If the 60 calendar day period in which to file a request for a redetermination has expired, an enrollee or a prescribing physician or other prescriber acting on behalf of an enrollee may file a request for redetermination and extension of time frame with the Part D plan sponsor. The request for redetermination and to extend the timeframe must—
 - (i) Be in writing; and
- (ii) State why the request for redetermination was not filed on time.
- (d) Withdrawing a request. The person who files a request for redetermination